

EXHIBIT A

(walmsley (mattingly).txt

REALTIME TRANSLATION - ROUGH EDIT ONLY 1

1 UNITED STATES DISTRICT COURT
2 SOUTHERN DISTRICT OF WEST VIRGINIA
3 CHARLESTON DIVISION
4
5

6 IN RE: ETHICON, INC. : Master File
7 PELVIC REPAIR SYSTEM : No.
8 PRODUCTS LIABILITY : 2:12-MD-02327
LITIGATION :
9 DEBORAH MATTINGLY, et : MDL NO. 2327
al :
10 v. : CASE NO.
11 : 2:12-cv-03097
12 ETHICON, INC., et al. :
13

14 October 12, 2016
15

16 Expert deposition of
17 KONSTANTIN WALMSLEY, M.D., taken pursuant
to notice, was held at Regus - North
18 America, One Gateway Center, Suite 2600,
Newark, New Jersey, beginning at 2:32
19 p.m., on the above date, before Kimberly
A. Cahill, a Federally Approved
20 Registered Merit Reporter and Notary
Public.
21

22
23 GOLKOW TECHNOLOGIES, INC.
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24 deps@golkow.com
25

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2 [!WITNESS NAME], called for Oral Examination in the
3 above-captioned matter, said deposition taken
4 pursuant to Superior Court Rules of Practice and
5 Procedure by and before KIMBERLY A. CAHILL, a
6 Federally Approved Registered Merit Reporter,
7 Certified Court Reporter, and Notary Public for the
8 State of New Jersey, at the offices of [!FIRM17],
9 [!ADDRESS-A17], [!ADDRESS-B17], [!CITY17],
10 [!STATE17], commencing at TIME ^ a.m. ^ p.m.

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1 APPEARANCES:

2

3

4

[!FIRM1]
BY: [!ATTORNEY1], ESQUIRE
BY: [!ATTORNEY1A], ESQUIRE
Page 2

(walmsley (mattingly).txt
5 [!ADDRESS-A1]
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9 [!FIRM2]
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BY: [!ATTORNEY2A], ESQUIRE
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15 [!FIRM3]
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BY: [!ATTORNEY3A], ESQUIRE
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Representing the Defendant

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VIDEOTAPE TECHNICIAN:
[!VIDEOGRAPHER]

ALSO PRESENT:
NAMES

(walmsley (mattingly).txt

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[!WITNESS NAME], after having been
duly sworn, was examined and testified as
follows:

- - -

- - -

EXAMINATION

- - -

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10 BY MS. STEINMETZ:

11 Q. Good afternoon, doctor. Can you
12 state your name for the record please?

13 A. Konstantin Walmsley.

14 Q. Dr. Walmsley, my name is Jennifer
15 Steinmetz. We met before the deposition. I'm going
16 to be asking you some questions today about the
17 Deborah Mattingly case. Do you understand that's
18 the reason you're here today?

19 A. Yes.

20 Q. And if I ask you a question and you
21 don't understand it, please ask me to rephrase.
22 Fair?

23 A. Yes.

24 Q. If you answer a question, I will
25 assume that you have understood the question. Can

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1 we have that agreement?

2 A. Yes.

3 Q. And you have given other depositions
4 in the pelvic mesh litigation?

5 A. I have.

6 Q. And can I rely on your sworn
7 testimony from those depositions?

8 A. Absolutely.

9 Q. And you understand that the purpose
10 of today's deposition is to explore your case
11 specific opinions in the case of Deborah Mattingly?

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12 A. Correct.
13 Q. Have you done a physical examination
14 on Ms. Mattingly?
15 A. No.
16 Q. Has anyone requested that you do a
17 physical examination on Ms. Mattingly?
18 A. No.
19 Q. Have you ever met Ms. Mattingly in
20 person?
21 A. I have not.
22 Q. Have you ever spoken with Ms.
23 Mattingly?
24 A. I have not.
25 Q. Have you communicated with her in

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1 writing?
2 A. No.
3 MS. STEINMETZ: Let's mark the notice
4 as deposition exhibit 1.
5 - - -
6 (Deposition Exhibit No. ##,
7 DESCRIPTION, was marked for
8 identification.)
9 - - -
10 BY MS. STEINMETZ:
11 Q. Doctor, have you seen Exhibit 1 prior
12 to today?
13 A. I have.
14 Q. Did you bring any documents with you

(walmsley (mattingly).txt

15 responsive to Schedule A of the deposition notice or
16 I guess it's Exhibit A of the deposition notice?

17 A. I have not. Generally speaking,
18 either my counsel will provide a thumb drive of the
19 medical records and depositions that I have
20 reviewed, and I believe I've provided in past prior
21 testimonies, those lists.

22 Q. Do you have a list either on the
23 computer that you brought with you today or
24 somewhere in hard copy version of the medical
25 records and deposition transcripts you have reviewed.

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1 in this case?

2 A. Yes.

3 Q. What deposition transcripts have you
4 reviewed?

5 A. Mrs. Mattingly, Dr. Angel, and Dr.
6 Shively.

7 Q. Did you review the deposition of Dr.
8 Samuel Kriegler taken on August 25th, 2016?

9 A. I do not believe so, no.

10 Q. Did you review the depositions of Ms.
11 Mattingly, Dr. Angel, and Dr. Shively sometime
12 between the time your report was written in July and
13 the present day?

14 A. Correct.

15 Q. Do you have a list of the medical
16 records you have reviewed?

17 (walmsley (mattingly).txt
18 A. I do not on this computer, but they
19 should be provided within my report.

20 MS. STEINMETZ: Let's go ahead and
21 mark your report as deposition Exhibit 2.

22 - - -
23 (Deposition Exhibit No. ##,
24 DESCRIPTION, was marked for
25 identification.)
- - -

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1 BY MS. STEINMETZ:

2 Q. Is Exhibit 2 your case specific
3 report for Deborah Mattingly?

4 A. Yes, it is.

5 Q. This report is dated July 22nd, 2016?

6 A. Correct.

7 Q. Is your report accurate?

8 A. It is.

9 Q. Is your report complete?

10 A. Yes, it is. Based on the medical
11 records that I reviewed at that time, yes.

12 Q. And at that time, the medical records
13 you had reviewed included Dr. Basim Kahleifeh,
14 Spring View Urology, Spring View Hospital, and
15 Taylor Regional Hospital?

16 A. That's correct.

17 Q. And is it your understanding that
18 Spring View Urology is the practice of a Dr.
19 Kriegler?

(walmsley (mattingly).txt

20 A. That's correct.

21 Q. Did you review the records of Dr.

22 Angel's practice, Taylor regional urology?

23 A. I believe they may have been included

24 in some of the other medical records that I

25 reviewed, because I believe my report may have made

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1 reference to that. Which records are you speaking
2 of again?

3 Q. Records from Dr. Angel's practice and
4 that practice is called Taylor regional urology?

5 A. I believe I have, although I don't
6 see that referenced in my list of medical, because I
7 believe Dr. Kriegler's records had the copies of Dr.
8 Angel's records in his, if you will. Does that make
9 sense? So in other words, Spring View Urology had
10 Dr. Angel's records copied into them. Does that
11 make sense?

12 Q. Yes, it does, thank you.

13 A. Yeah.

14 Q. Do you have a recollection of
15 receiving a separate set of records which came
16 directly from Dr. Angel's practice?

17 A. I do not recall that, no.

18 Q. Did you review records from Dr.
19 Shively's practice, Taylor regional surgical
20 associates?

21 A. Yes.

(walmsley (mattingly).txt
22 Q. And did you receive those as a
23 separate set or were those contained within Dr.
24 kriegler's records?
25 A. Within those records and those of

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1 Taylor Regional Hospital.
2 Q. Did you review records from Ms.
3 Mattingly's treating primary care practice, Lebanon
4 medical associates?
5 A. Do you have any of the specific
6 physicians' names?
7 Q. I know that Dr. Kirk was her primary
8 care provider. Does his name sound familiar to you?
9 Q. That name does not sound familiar to
10 me.
11 A. At the time that you wrote your
12 report back in July, you listed the medical records
13 that you had reviewed as of that time.
14 A. That's correct.
15 Q. Have you reviewed medical records
16 since you've prepared this report?
17 A. No new medical records, no.
18 Q. Can I rely on what you have written
19 in your report?
20 A. Yes.
21 Q. Can I rely on the opinions you are
22 giving today as final opinions?
23 A. Pending any additional information,
24 yes.

(walmsley (mattingly).txt

25 Q. Are there any additional reports that

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1 you have authored in this case?

2 A. No.

3 MS. STEINMETZ: Let's mark Exhibit A
4 to your report as deposition Exhibit 3.

5 - - -

6 (Deposition Exhibit No. ##,
7 DESCRIPTION, was marked for
8 identification.)

9 - - -

10 BY MS. STEINMETZ:

11 Q. Is this a copy of your current
12 curriculum vitae, doctor?

13 A. Yes, it is.

14 MS. STEINMETZ: And let's mark
15 Exhibit B to your report as Deposition Exhibit No.
16 4.

17 - - -

18 (Deposition Exhibit No. ##,
19 DESCRIPTION, was marked for
20 identification.)

21 - - -

22 BY MS. STEINMETZ:

23 Q. Is this a copy of your reliance list
24 for this case?

25 A. Yes, it is.

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1 Q. And am I correct that the reliance
2 list at Exhibit 4 lists the materials and the
3 medical literature you have reviewed in connection
4 with this case?

5 A. Yes.

6 Q. Are you relying on any materials or
7 literature outside of this reliance list in support
8 of your opinions?

9 A. No, I hadn't -- no.

10 Q. Did you conduct a medical literature
11 search specific to the Deborah Mattingly case?

12 A. This is a kind of a live bibliography
13 that relates to articles that I feel are relevant to
14 the opinions that I render in these types of
15 matters, so as new information or new I think well
16 peer reviewed articles evolve, I'll add them to the
17 list, so this one is --

18 Q. Was there anything specific --

19 A. I'm sorry.

20 Q. Go ahead. No, go ahead. Finish your
21 answer, please.

22 A. So this was the current list as of
23 that period of time, which would have been, you
24 know, early July of 2016.

25 Q. Do you have a memory of conducting

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REALTIME TRANSLATION - ROUGH EDIT ONLY 14

(walmsley (mattingly).txt

1 any particular literature search based on the
2 conditions or the symptomology that you reviewed
3 related to this particular plaintiff, Deborah
4 Mattingly?

5 A. No.

6 Q. The first item on the list refers to
7 depositions of medical providers. Do you see that?

8 A. Correct. Yes.

9 Q. And it looks like you reviewed Dr.
10 Angel and Dr. Shively's depositions, but not Dr.
11 Kriegler; is that right?

12 A. That's correct.

13 Q. And again you reviewed those
14 depositions after you prepared your report.

15 A. Yes.

16 Q. True?

17 A. Yes.

18 Q. Is that why they're not listed in
19 your report?

20 A. Correct.

21 Q. Have you communicated with any of Ms.
22 Mattingly's treating physicians?

23 A. No.

24 Q. The second item on your reliance list
25 refers to depositions of client and partner and you

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1 said that you reviewed Ms. Mattingly's deposition?

2 A. I did.

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3 Q. And was that after you prepared your
4 report?

5 A. Yes.

6 Q. Is that why her deposition is not
7 listed on your report?

8 A. Yes.

9 Q. The third item refers to expert
10 reports related to this case.

11 A. Right.

12 Q. Do you see that?

13 A. Yes.

14 Q. Are you relying on reports or
15 opinions of any other expert in support of your
16 opinions in this case?

17 A. No.

18 Q. And does your report specifically
19 mention any other expert reports or opinions upon
20 which you have relied?

21 A. This is fairly comprehensive. Could
22 you repeat --

23 Q. When you say this, are you referring
24 to your report?

25 A. Yeah.

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1 Q. And I guess just to reiterate the
2 question, does your report list any other expert
3 reports that you are relying on?

4 A. No.

5 Q. The fourth item on your reliance list
Page 14

(walmsley (mattingly).txt

6 refers to medical and billing records.

7 A. Yes.

8 Q. And you've listed those medical
9 records on page 2 of your report?

10 A. Yes.

11 Q. And we talked about some medical
12 records that you may have reviewed that are not on
13 this list. Is this the extent of what you reviewed
14 as far as medical records go?

15 A. Yes.

16 Q. Are there any specific billing
17 records that you rely upon in support of your
18 opinions?

19 A. No.

20 Q. The fifth item refers to instructions
21 for use and that's known as an IFU. Right?

22 A. Correct.

23 Q. Are you referring to the TVT
24 instructions for use?

25 A. Correct.

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1 Q. In this reliance list?

2 A. Yes.

3 Q. All right.

4 Are you relying on the instructions
5 for use for any other Ethicon product in support of
6 your opinions in this case?

7 A. No.

(walmsley (mattingly).txt
8 Q. You also mention here the TVT patient
9 brochure. Do you see that?

10 A. I do.

11 Q. Other than the instructions for use
12 and the brochure for the TVT sling, did you -- let
13 me ask that a better way. Strike that. Other than
14 the instructions for use for the TVT and the patient
15 brochure for the TVT, are you relying on any other
16 Ethicon-created document in support of your
17 opinions?

18 A. No.

19 Q. Have you read the report of Ethicon's
20 expert, Dr. Greg veils?

21 A. No, I don't believe so.

22 Q. Do you know Dr. Greg veils at the
23 university of Chicago?

24 A. No.

25 Q. I'm sorry. Did you have an answer or

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REALTIME TRANSLATION - ROUGH EDIT ONLY 18

1 were you looking something up?

2 A. You asked me if I knew him. I do not
3 know him. I'm sorry. I thought -- I said no. I
4 apologize.

5 Q. That's okay.

6 Switching gears a little bit, to
7 date, how many pelvic mesh cases approximately have
8 you testified in?

9 A. Between 15 and 20.

10 Q. Have you testified exclusively for
Page 16

(walmsley (mattingly).txt

11 the plaintiffs in the pelvic mesh litigation?

12 A. Somewhat. I mean, I've been offered
13 cases by plaintiffs that I felt weren't plaintiffs'
14 cases and I've looked at cases from defendants
15 relating to pelvic mesh cases, but as far as
16 testimony is concerned, yes, only for plaintiffs.

17 Q. And what is your hourly rate, doctor?

18 A. \$500 an hour.

19 Q. Does that rate change for deposition
20 versus trial testimony?

21 A. No.

22 Q. How much have you earned to date with
23 respect to your services in the pelvic mesh
24 litigation?

25 A. I would estimate over the last two to

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1 three years, perhaps 10020,000 to 140,000. I'm not
2 specifically sure.

3 Q. When were you first contacted about
4 the Deborah Mattingly case?

5 A. In April or May of 2016.

6 Q. Who contacted you?

7 A. Mr. Barreca.

8 Q. And what were you told about the
9 case?

10 A. I was told that this was a case of a
11 lady who had a sling placed, who had complications
12 of pelvic pain and dyspareunia, amongst other things

(walmsley (mattingly).txt
13 and they asked me if I would take a look at the
14 medical records and provide an opinion relating to
15 them.

16 Q. And at the time you were first
17 contacted about this case, you had worked for Mr.
18 Barreca's law firm before?

19 A. That's correct.

20 Q. And what specifically were you asked
21 to do in connection with this case?

22 A. I was asked to look at medical
23 records and provide an opinion regarding the outcome
24 of those -- or the analysis of those medical records
25 as it relates to complications from slings, in this

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1 case a TVT sling.

2 Q. At the outset, did you know that you
3 would be writing a report or asked to write a
4 report?

5 A. Well, I knew I was going to be asked
6 to write a report, but I wouldn't write the report
7 unless I felt there was some merit to my client of
8 writing said report, in other words, if I felt like
9 the patient had a complication that could be
10 excluded with a reasonable degree of medical
11 certainty as it relates to, in this case, the
12 device, then I wouldn't recommend writing a report
13 unless they wanted me to anyway.

14 Q. How did you go about deciding which
15 records and depositions were important to review?

(walmsley (mattingly).txt

16 A. Well, my general practice is to
17 review as many records as possible. There can be
18 never too many medical records to be reviewed in
19 these cases, because in a lot of cases, they kind of
20 cross into different fields and paths, you know,
21 primary care, sometimes the, you know, psychological
22 impact and such so I like to get as many medical
23 records as possible so when a case is provided to
24 me, I'm assuming that the records being provided to
25 me are complete or at least complete as it relates

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1 to the entire matter.

2 Q. And you rely on Ms. Mattingly's
3 counsel to provide those records to you?

4 A. I do. I do.

5 Q. And is the same true for depositions;
6 you want to see as many of them as possible?

7 A. Depositions are a little bit
8 different because a lot of times they're not
9 initially offered to me so I have to ask for them
10 kind of post facto and to some degree, they're --
11 you know, they're -- getting them can be a little
12 different for me. So generally speaking I don't
13 usually get all the depositions but I like to see
14 the depositions of treating physicians and/or
15 explanting physicians as well because I feel
16 sometimes that they can add to clarity of the
17 medical records.

(walmsley (mattingly).txt
18 Q. If Ms. Mattingly came to you as a
19 patient, what would be your normal methodology for
20 diagnosing her?
21 A. Well, certainly a history and a
22 physical would be mandatory. I would want to review
23 all of her medical records and operative notes as it
24 relates to her pelvic surgery and her pelvic
25 symptoms and that would be a good start, and my

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1 history and physical usually does include
2 urinalyses, sometimes urodynamics and/or cystoscopic
3 evaluations and such. This is the kind of patient
4 that would likely need a comprehensive medical
5 evaluation because of her somewhat complicated
6 history.
7 Q. You agree that the physical exam is
8 important in the overall care and treatment of a
9 patient for whom you are going to provide a
10 diagnosis.
11 A. Well, I think certainly in an ideal
12 world, one would have the ability to do that as a
13 treating physician. But sometimes in the world that
14 I live in, I have to superimpose the medical
15 evidence to kind of represent those exams, so that's
16 what I had to do in the Mattingly matter. I didn't
17 have the opportunity to examine her myself,
18 obviously, so I had to rely on the medical records
19 and what was within them as far as her examination
20 is concerned.

(walmsley (mattingly)).txt

21 Q. Would you agree that Ms. Mattingly's
22 treating physicians are in a better position to
23 diagnose her given that they have been able to
24 conduct that physical examination?
25 A. I would think so.

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1 Q. Did you bring your invoices for the
2 Deborah Mattingly case with you today?
3 A. You know, I did not and I was
4 thinking about it on the way here that I forgot to
5 have, just because there was a little bit of a time
6 lag between the report and us getting together,
7 which I apologize for actually but -- so I don't
8 have them with me.
9 Q. Could you provide that to your
10 counsel after this deposition?
11 A. Absolutely.
12 Q. All right. Do you know how much
13 time, approximately, you spent preparing your report
14 in this case?
15 A. I believe roughly six hours if my
16 memory serves me.
17 Q. And do you recall how much time you
18 spent preparing for your deposition today?
19 A. Well, the report was another two to
20 three hours and then preparing for the deposition,
21 which also related to reviewing the additional
22 depositions, was probably on the order of about five

(walmsley (mattingly).txt
23 hours to six hours or so, max.

24 Q. Maybe I could ask it a better way:
25 Do you know approximately the total number of hours

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REALTIME TRANSLATION - ROUGH EDIT ONLY 24

1 that you spent on this case thus far?

2 A. Roughly ten.

3 Q. And are there any medical records in
4 particular that you believe are missing that you'd
5 like to still see?

6 A. No.

7 Q. Any depositions you believe are
8 missing that you would like to see?

9 A. No.

10 Q. Again switching gears I just wanted
11 to ask you a few questions about your
12 qualifications. And I've read some of your past
13 depositions so I'm not going to get into this too
14 far but I just want to be clear. Am I correct that
15 you do not hold yourself out as an expert in
16 chemistry?

17 A. That's correct.

18 Q. Am I correct that you do not hold
19 yourself out as an expert in toxicology?

20 A. Yes.

21 Q. Am I correct that you do not hold
22 yourself out as an expert in epidemiology?

23 A. You are correct.

24 Q. Am I correct that you do not hold
25 yourself out as an expert in pathology?

(walmsley (mattingly).txt

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1 A. That's correct.

2 Q. Am I correct that you do not hold
3 yourself out as an expert on FDA medical device
4 regulations?

5 A. Correct.

6 Q. Have you ever been employed with or
7 consulted with the F D -- strike that. Have you
8 ever been employed by or consulted with the FDA?

9 A. No.

10 Q. Have you ever served on any type of
11 FDA advisory committee?

12 A. I have not.

13 Q. Have you ever written or been asked
14 to write an instructions for use for a medical
15 device product?

16 A. No.

17 Q. Have you ever consulted with a
18 medical device manufacturer about information to be
19 included in an instructions for use?

20 A. Could you repeat the question? I'm
21 sorry.

22 Q. Sure. Have you ever consulted with a
23 medical device manufacturer about what should or
24 should not be included in an IFU?

25 A. No, not directly.

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(walmsley (mattingly).txt
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1 Q. And you have implanted polypropylene
2 mid-urethral slings yourself; correct?

3 A. I have.

4 Q. And I believe you previously
5 testified you implanted approximately 300 to 500
6 mid-urethral slings, including your fellowship and
7 private practice? Does that sound right?

8 A. Yes.

9 Q. And do you still currently use
10 polypropylene mid-urethral slings from time to time?

11 A. I do.

12 Q. You currently implant approximately
13 20 polypropylene mid-urethral slings each year; do I
14 have that right?

15 A. Yes.

16 Q. If a patient is appropriately
17 counseled, you believe a polypropylene mid-urethral
18 may be the best option in some cases.

19 MR. BARRECA: Objection to form.

20 BY MS. STEINMETZ:

21 Q. Correct?

22 A. I do.

23 Q. Do you know the extent of the
24 counseling provided to Ms. Mattingly by Dr. Angel?

25 MR. BARRECA: Objection to form.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 27

1 BY MS. STEINMETZ:

(walmsley (mattingly).txt

2 Q. In this specific case?

3 A. Well, what's inherent to the medical
4 records, yes.

5 Q. Do you believe Dr. Angel's counseling
6 was appropriate?

7 A. I believe it was.

8 Q. And you are relying on the testimony
9 of Dr. Angel and Ms. Mattingly herself in support of
10 that opinion?

11 A. Correct.

12 Q. Have you ever implanted an Ethicon
13 TVT sling, like the one used with Ms. Mattingly?

14 A. I have.

15 Q. How many TVT slings made by Ethicon
16 have you implanted over the course of your practice?

17 A. I should -- I should actually amend
18 that, because because -- no, I stand corrected. I
19 have. The only -- I haven't done TVT Obturator
20 slings, but I've done some of the TVT Classic
21 slings.

22 Q. The retropubic approach?

23 A. Correct.

24 Q. How many of those have you implanted
25 over the course of your career, doctor?

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REALTIME TRANSLATION - ROUGH EDIT ONLY 28

1 A. Probably between 25 and 40, but they
2 were almost all during my fellowship.

3 Q. After that time, I believe you've

(walmsley (mattingly).txt
4 used Bard products?

5 A. Mostly Bard but a smattering of
6 others, yes.

7 Q. Let's turn to your opinions specific
8 to Ms. Mattingly.

9 A. Okay.

10 Q. Now, you are aware that Ms. Mattingly
11 had a retropubic sling implanted by Dr. Angel in
12 March of 2009 for treatment of stress urinary
13 incontinence?

14 A. Correct.

15 Q. And do you agree that placement of a
16 TVT for stress urinary incontinence was within the
17 standard of care in March of 2009?

18 A. I do agree.

19 Q. Are you critical of the technique
20 used by Dr. Angel to place the TVT?

21 A. I'm not.

22 Q. During that surgery, Dr. Angel also
23 did a native tissue repair for her grade 3 bladder
24 prolapse; correct?

25 A. That's correct.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 29

1 Q. During that surgery, Dr. Angel also
2 did a posterior native tissue repair for her grade 2
3 prolapsed rectum; correct?

4 A. Correct.

5 Q. And the posterior repair required a
6 separate vaginal incision; correct?

(walmsley (mattingly).txt

7 A. Correct.

8 Q. Do you agree that a native tissue
9 repair for pelvic organ prolapse was within the
10 standard of care in March 2009?

11 A. I do.

12 Q. Are you critical of the technique
13 used by Dr. Angel in performing either of the native
14 tissue repairs?

15 A. I'm not.

16 Q. You are aware that subsequent to Dr.
17 Angel's surgery, Ms. Mattingly developed prolapse of
18 the bladder and vaginal vault which necessitated a
19 sacrocolpopexy procedure which she had done in May
20 of 2011?

21 A. Yes.

22 Q. And can we agree that the prolapse
23 that developed between March of 2009 and May of 2011
24 was not related to the TVT?

25 A. I would agree with that.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 30

1 Q. And the sacrocolpopexy was done by
2 Dr. Shively and he used Prolene mesh as a bridge
3 between the vagina and the sacrum?

4 A. That's correct.

5 Q. Do you agree that an abdominal
6 sacrocolpopexy for prolapse was within the standard
7 of care in May of 2011?

8 A. I agree.

(walmsley (mattingly).txt
9 Q. Are you critical of the technique
10 used by Dr. Shively in the 2011 sacrocolpopexy
11 procedure?

12 A. I'm not.

13 Q. Do you have any criticism of Dr.
14 Shively's use of Prolene mesh in that procedure?

15 A. No, I don't.

16 Q. In this case, are you going to be
17 offering the opinion that the Prolene mesh used by
18 Dr. Shively in May of 2011 was defective in some
19 way?

20 A. No.

21 Q. In this case, are you going to be
22 offering any opinions critical of the warnings
23 associated with the Prolene mesh used by Dr. Shively
24 in May of 2011?

25 A. No, I'm not.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 31

1 Q. Is there any particular symptom or
2 complaint of Ms. Mattingly that you causally relate
3 to the Prolene mesh implanted by Dr. Shively in
4 2011?

5 A. I wouldn't exclude it.

6 Q. You wouldn't exclude it for what
7 problem or complaint?

8 A. I wouldn't exclude it from the
9 complaints of pelvic pain. I think it should be in
10 the differential.

11 Q. Any other problem or complaint that
Page 28

(walmsley (mattingly).txt

12 you would not exclude related to the Prolene mesh?

13 A. No.

14 Q. Are you going to be offering the
15 opinion that the Prolene mesh more likely than not
16 was the cause of Ms. Mattingly pelvic pain?

17 A. No.

18 Q. Let's talk a little about Ms.
19 Mattingly's history leading up to her treatment with
20 Dr. Angel. Now, you are aware that Ms. Mattingly
21 had two pregnancies and two vaginal deliveries?

22 A. I am.

23 Q. Are pregnancies and vaginal
24 deliveries risk factors for developing stress
25 urinary incontinence?

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REALTIME TRANSLATION - ROUGH EDIT ONLY 32

1 A. Yes.

2 Q. Are pregnancies and vaginal
3 deliveries risk factors for developing pelvic organ
4 prolapse?

5 A. Yes.

6 Q. Would you agree that age is a risk
7 factor for stress urinary incontinence?

8 A. Ever in and of itself, yes.

9 Q. And would you agree that age is a
10 risk factor for pelvic organ prolapse?

11 A. Yes.

12 Q. Would you agree that obesity is a
13 risk factor for stress urinary incontinence?

14 (walmsley (mattingly).txt
14 A. Yes.

15 Q. would you agree that obesity is a
16 risk factor for pelvic organ prolapse?

17 A. I would agree.

18 Q. Is a height of 5, 1 with a weight of
19 169 pounds considered obese?

20 A. I'd have to get a specific BMI to
21 answer that question from a purely objective
22 standpoint, but it sounds overweight to me.

23 Q. What BMI measure do you categorize as
24 obese?

25 A. I think over 40 is morbidly obese,

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REALTIME TRANSLATION - ROUGH EDIT ONLY 33

1 but somewhere in the 30s would be a start for cause
2 of concern.

3 MS. STEINMETZ: Let's mark as Exhibit
4 5 a questionnaire from Dr. Angel's records dated
5 February 9th, 2009.

6 - - -

7 (Deposition Exhibit No. ##,
8 DESCRIPTION, was marked for
9 identification.)

10 - - -

11 BY MS. STEINMETZ:

12 Q. Is this what appears to be a two-page
13 questionnaire, Doctor, dated February 9th, 2009?

14 A. Yes.

15 Q. Did you review this questionnaire in
16 preparation for either writing your report or your

(walmsley (mattingly).txt

17 deposition today?

18 A. Yes.

19 Q. Ms. Mattingly's chief complaint when
20 she presented to Dr. Angel was rectocele, cystocele,
21 prolapsed bladder; is that right?

22 A. Yes.

23 Q. And at that time, under
24 gastrointestinal, she reported change in bowel
25 movements, nausea or vomiting, painful bowel

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REALTIME TRANSLATION - ROUGH EDIT ONLY 34

1 movements, constipation, rectal bleeding or blood in
2 stool, and abdominal pain; is that correct?

3 A. Yes.

4 Q. And under genitourinary, she
5 self-reported frequent urination, burning or painful
6 urination, change in force of stream, incontinence
7 or dribbling; is that right?

8 A. Yes.

9 Q. She also reported under
10 musculoskeletal, bone pain, back pain and difficulty
11 walking; correct?

12 A. Yes.

13 Q. On page 2 of Exhibit 5, under past
14 medical history, Ms. Mattingly reported arthritis,
15 bladder infections, and back trouble; is that
16 correct?

17 A. Yes.

18 Q. And over in the second column, she

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19 also reported scarring in her stomach due to chronic
20 gastritis?

21 A. I see that.

22 Q. She reported herself disabled at the
23 time she first presented to Dr. Angel?

24 A. Correct.

25 Q. Did you take Ms. Mattingly's past

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REALTIME TRANSLATION - ROUGH EDIT ONLY 35

1 medical history had into account when forming your
2 opinions in this case?

3 A. I did.

4 MS. STEINMETZ: Let's also mark as
5 Exhibit 6 a copy of a bladder health questionnaire
6 dated March 6, 2009.

7 - - -

8 (Deposition Exhibit No. ##,
9 DESCRIPTION, was marked for
10 identification.)

11 - - -

12 BY MS. STEINMETZ:

13 Q. And I will represent to you that Ms.
14 Mattingly testified this is a questionnaire that Dr.
15 Angel's office asked that she complete in
16 conjunction with her urodynamics testing done before
17 her procedure.

18 A. Yes.

19 Q. You recall that from her testimony?

20 A. Yes.

21 Q. Have you seen this bladder health

(walmsley (mattingly).txt

22 questionnaire prior to today?

23 A. I have.

24 Q. Ms. Mattingly reported urinating five
25 or six times during the day and getting up two times

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REALTIME TRANSLATION - ROUGH EDIT ONLY 36

1 per night to urinate?

2 A. Yes.

3 Q. And she reported to Dr. Angel in
4 March of 2009 that her bladder problems began in the
5 year 2004?

6 A. Yes.

7 Q. Ms. Mattingly reported a strong sense
8 of urgency to urinate?

9 A. Yes.

10 Q. And she reported pain when her
11 bladder was full?

12 A. Yes.

13 Q. She also reported that she could not
14 postpone emptying her bladder easily; is that
15 correct?

16 A. Yeah, she stated that she could not
17 do that.

18 Q. What do those three answers that we
19 just talked about -- what do those mean to you as a
20 urologist?

21 A. Well, they speak to several different
22 issues, you know, one being the concept of pelvic
23 pain, the other being the concept of overactive

24 bladder. (walmsley (mattingly).txt

25 Q. And overactive bladder has components

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1 of both urinary frequency and urinary urgency?

2 A. Yeah, usually urinary urgency is
3 actually the most important of those symptoms, in
4 fact. From the standpoint of urinary frequency, she
5 actually doesn't fall under the definition of really
6 having frequency.

7 Q. Oh, based on the five to six times a
8 day and the two times per night?

9 A. Yeah, because the international
10 continence society defines urinary frequency as
11 actually urinating greater than eight times in a
12 24-hour period. So from an objective standpoint,
13 she wouldn't fall under the criteria, if you will,
14 of having urinary frequency based on this
15 questionnaire at least.

16 Q. Based on this questionnaire, she
17 falls into the category of urinary urgency; correct?

18 A. Yes.

19 Q. And based on this questionnaire, she
20 self-reports symptoms of pelvic pain; correct?

21 A. Well, it's not specified as pelvic,
22 but I am concluding that a full bladder would
23 relate, if there is pain, to pain in that area.

24 Q. I'm sorry. I thought I heard you say
25 pelvic pain earlier.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 38

1 A. Yeah, no, I think -- definitely, I
2 guess pelvic pain is -- is in the differential of
3 pain, but she actually, as is self-reported prior,
4 has back pain and other areas of pain, so I'm not
5 sure when she says pain when your bladder is full if
6 that is, strictly speaking, localized to the
7 bladder. That's just not my conclusion there. It's
8 not a completely specific question as it relates to
9 the source of pain, shall we say.

10 Q. But in any event, she reports some
11 kind of pain in the pelvic area before she even has
12 the sling put in.

13 A. Fair.

14 Q. Correct?

15 A. I think that's a fair assessment.

16 Q. The next section talks about loss of
17 urine. Do you see that?

18 A. I do.

19 Q. And she reports loss of urine when
20 she sneezes, coughs, jumps, runs, and laughs. Is
21 that consistent with stress urinary incontinence?

22 A. Yes.

23 Q. And she reports a loss of urine when
24 she cannot make it to the bathroom on time.

25 A. Correct.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 39

(walmsley (mattingly).txt

1 Q. Is that consistent -- is that
2 consistent with urge incontinence?

3 A. Yes.

4 Q. And Ms. Mattingly reported leaking a
5 couple times a day as of March of 2009?

6 A. Yes.

7 Q. She also reported in March of 2009,
8 prior to the surgery, difficulty starting her urine
9 stream; is that correct?

10 A. Yes.

11 Q. And she describes that difficulty as
12 the need to push or strain and wait more than one
13 minute for her stream to start; correct?

14 A. Yes.

15 Q. What does that tell you from a
16 urologic perspective?

17 A. Well, it tells me that she has
18 several different disease state dynamics. I mean
19 one of them obviously is stress urinary incontinence
20 based both on her complaints and her physical
21 examination. These specific complaints to me speak
22 more to the significance of her cystocele, because
23 cystoceles as they become more severe tend to cause
24 voiding dysfunction by virtue of the change in the
25 anatomical angle between the bladder neck and the

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REALTIME TRANSLATION - ROUGH EDIT ONLY 40

1 bladder when cystoceles get worse.

2 In other words when a bladder starts
Page 36

(walmsley (mattingly).txt

3 to drop, it kind of kinks the bladder outlet and
4 that can generate the symptoms that she's discussing
5 as far as difficulty starting urine stream, pushing,
6 straining, dribbling, and so forth.

7 Q. Any other factors that you would
8 include in a differential for difficulty starting
9 urine stream other than the cystocele?

10 A. Only a severe back injury, which I
11 don't believe she had a history of other than a
12 herniated disc but a herniated disc should not cause
13 a neurogenic bladder, for example.

14 Q. She also states in this questionnaire
15 that when she's urinating, she cannot stop the
16 stream; is that right?

17 A. Yes.

18 Q. She has -- she thinks that she does
19 not completely empty her bladder.

20 A. Yes.

21 Q. She also notices dribbling of urine
22 after emptying her bladder.

23 A. Correct.

24 Q. Are those signs of retention?

25 A. Possibly.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 41

1 Q. And would that be due to likely the
2 cystocele in your opinion?

3 A. Yes, in theory.

4 Q. Any other potential causes other than

(walmsley (mattingly).txt
5 the cystocele for those symptoms?

6 A. Either the presence of scar tissue
7 within the urethra or some sort of voiding
8 dysfunction that the patient had separate to the
9 prolapse.

10 Q. And what do you mean by voiding
11 dysfunction in that last answer?

12 A. Incomplete bladder emptying, for
13 example, some of the irritative bladder symptoms,
14 the fact that her incontinence is of a mixed fashion
15 certainly increases the possibility of other disease
16 states influencing her voiding function.

17 Q. Based on the questionnaire and the
18 health history we just looked at, would you agree
19 that Ms. Mattingly had a complex urologic picture as
20 of the time that she presented to Dr. Angel in March
21 of 2009?

22 MR. BARRECA: Can you repeat that?

23 I'm sorry.

24 MS. STEINMETZ: I'm sorry. I don't
25 think I can. Can you repeat it back for him, Kim?

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REALTIME TRANSLATION - ROUGH EDIT ONLY 42

1

- - -

2

(The court reporter read the

3

pertinent part of the record.)

4

- - -

5

MR. BARRECA: I'm going to object to

6

the form of that question. You can answer that.

7

THE WITNESS: Not especially.

(walmsley (mattingly).txt

8 BY MS. STEINMETZ:

9 Q. If you were treating this patient and
10 she came to you with the complaints listed in
11 exhibits 5 and 6, without examination, what would
12 you diagnose her with urologically speaking?

13 A. I would diagnose her with mixed
14 urinary incontinence, likely cystocele, possible
15 rectocele, possible apical prolapse based on her
16 partial hysterectomy, pelvic pain and urgency and
17 nocturia.

18 Q. And you agree with me that prior to
19 Ms. Mattingly's March 2009 TVT surgery, she had a
20 history of bladder infections.

21 A. That's correct.

22 Q.

23 MS. STEINMETZ: Let's look at the
24 operative report dated March 27th, 2009 which we
25 will mark as Exhibit 7.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 43

1 - - -
2 (Deposition Exhibit No. ##,
3 DESCRIPTION, was marked for
4 identification.)
5 - - -

6 BY MS. STEINMETZ:

7 Q. And you've seen Exhibit 7 prior to
8 today. Right, doctor?

9 A. I have.

(walmsley (mattingly).txt
10 Q. Dr. Angel performed an anterior and a
11 posterior native tissue repair at the time that he
12 placed the TVT?

13 A. Yes.

14 Q. The anterior colporrhaphy was
15 indicated for her cystocele?

16 A. Yes.

17 Q. And do you agree that Ms. Mattingly
18 was an appropriate candidate for this procedure
19 based on your review of the records?

20 A. Yes.

21 Q. The posterior colporrhaphy was
22 indicated for her prolapsed rectum; is that right?

23 A. Yes.

24 Q. And do you agree she was an
25 appropriate candidate for this procedure based on

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REALTIME TRANSLATION - ROUGH EDIT ONLY 44

1 your review of the records?

2 A. Correct.

3 Q. The TVT was indicated for her stress
4 urinary incontinence?

5 A. Yes.

6 Q. And you agree that Ms. Mattingly was
7 an appropriate candidate for this procedure?

8 A. I do.

9 Q. Is a native tissue repair for
10 prolapse in your view more invasive than a TVT
11 placement?

12 A. well, it depends on how one defines
Page 40

(walmsley (mattingly).txt

13 invasive. I would say no based on my definition of
14 invasive.

15 Q. How do you define invasive?

16 A. Well I think invasive can carry with
17 it a number of different implications, for example,
18 length of time, postoperative complication rates,
19 things of that nature. I mean, on one level, a
20 sling is actually usually done in a faster period of
21 time than an anterior repair. On the other hand,
22 even though the anterior repair takes longer, the
23 complications from using native tissue, for example,
24 as opposed to mesh-specific complications, would
25 render the anterior -- you know, the native tissue

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REALTIME TRANSLATION - ROUGH EDIT ONLY 45

1 repair, pardon me, a safer surgery than a
2 mid-urethral sling.

3 Q. You will agree with me that a native
4 tissue repair for prolapse carries its own
5 independent set of potential complications.

6 A. Yes.

7 Q. Infection and bleeding?

8 A. To some extent, yes.

9 Q. Wound complications?

10 A. Yes.

11 Q. Long-term pelvic pain?

12 A. Native tissue repairs less so, but
13 possibly.

14 Q. Long-term pain with intercourse?

(walmsley (mattingly).txt
15 A. Once again, I mean, with native
16 tissue repairs, not very common, but possible.
17 Q. Nerve damage?
18 A. The same.
19 Q. Injury to blood vessels of the
20 pelvis?
21 A. Yes.
22 Q. Injury to internal organs.
23 A. Possibly.
24 Q. Neuromuscular problems?
25 A. Less likely, but possible.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 46

1 Q. Voiding dysfunction?
2 A. Possibly.
3 Q. Inflammation?
4 A. It depends on what kind of
5 inflammation.
6 Q. What kind of inflammation, different
7 types of inflammation, do you believe are present or
8 can be present with a native tissue repair?
9 A. Well, I think of inflammation as
10 being really in two groupings, acute inflammation,
11 for example, the natural tissue healing that occurs
12 immediately after native tissue surgical repair, for
13 example, and also chronic inflammation, which
14 doesn't really apply to native tissue repairs but
15 certainly would apply to transvaginal polypropylene
16 mesh-based repairs.

17 Q. Are you saying that chronic
Page 42

(walmsley (mattingly).txt

18 inflammation is not possible with a native tissue
19 repair?

20 A. Typically not, unless you're using
21 permanent suture material which is not always used
22 for these types of repairs and certainly also
23 presents a lower load or amount, if you will, of
24 foreign body compared to mesh.

25 Q. So in the case where permanent

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REALTIME TRANSLATION - ROUGH EDIT ONLY 47

1 sutures are used, there is the potential
2 complication for chronic inflammation.

3 A. Yes.

4 Q. And in the case where permanent
5 sutures are used, there is a potential complication
6 of an increased foreign body response.

7 A. I would agree with that although I
8 think it also depends to some degree on the location
9 and the composition of the foreign body.

10 Q. Is scarring a potential complication
11 of any native tissue repair?

12 A. To some degree, yes.

13 Q. Tissue contraction?

14 A. To some degree, yes.

15 Q. Failure or recurrence?

16 A. Yes.

17 Q. Need for further surgical procedures
18 down the road?

19 A. That's a possibility.

(walmsley (mattingly).txt
20 Q. So whether or not Ms. Mattingly had
21 the TVT placed, she was at risk for all of the
22 complications we discussed given two native tissues
23 repairs that Dr. Angel performed for her prolapse;
24 is that correct?
25 MR. BARRECA: Objection to form.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 48

1 THE WITNESS: Well, yes, to some
2 degree, I think that's true, but there also -- I
3 mean, I think there are mesh-specific complications
4 that we really haven't discussed in that prior
5 dialogue between you and I.
6 BY MS. STEINMETZ:
7 Q. Right and I was just asking you about
8 a native tissue repair without the use of mesh.
9 A. Right.
10 Q. So I didn't ask about mesh
11 complications.
12 A. No, no, I understand -- I understand
13 that. I just felt like you were in a sense
14 attributing the complications she had to that
15 particular repair, which I just wanted to make clear
16 isn't reflective of my opinion.
17 Q. I understand.
18 A. Right.
19 Q. She had a TVT placed along with those
20 two repairs. Right?
21 A. Correct.
22 Q. So my question to you is, if Ms.

(walmsley (mattingly).txt

23 Mattingly had elected not to have the TVT placed and
24 she elected to have an anterior and a posterior
25 repair, would she have been at least at some risk of

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REALTIME TRANSLATION - ROUGH EDIT ONLY 49

1 all of the complications we just discussed?

2 A. I would agree with that.

3 Q. And similarly, the procedure that Dr.
4 Shively performed in May of 2011, she was at risk,
5 at least to some degree, for all of those potential
6 complications during that surgery as well; correct?

7 A. Yes, I would agree with that.

8 Q. And in addition to the complications
9 you and I talked about with the native tissue
10 repair, the procedure by Dr. Shively involved
11 Prolene mesh. Right?

12 A. Yes.

13 Q. So she was also at a risk of an
14 increased foreign body response; correct?

15 A. Well, yes, but I'd like to, you know,
16 preface the line of questioning just by saying that
17 this was different as far as location. It was
18 intraperitoneal mesh, so the literature would
19 support and be reflective of a favorable
20 complication rate when one is comparing transvaginal
21 mesh versus intraperitoneal mesh. So with a lot of
22 your questions, I'm probably going to say to a
23 lesser extent, but yes.

24 Q. Okay. So the --

25 A. (walmsley (mattingly).txt
To be fair.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 50

1 Q. So the -- what did you say at the
2 very end?

3 A. No no I'm sorry. I cut you off,
4 please.

5 Q. The intraperitoneal mesh that Dr.
6 shively used in May of 2011 carried with it some
7 complications, although you think those
8 complications were lower in frequency than perhaps
9 the TVT mesh that Dr. Angel used in 2009?

10 A. Possibly, yes, yeah.

11 Q. Dr. Angel removed vaginal tissue
12 during the 2009 procedure; is that correct?

13 A. He did.

14 MS. STEINMETZ: Let's look at the
15 pathology report which I've marked as Exhibit 8.

16 - - -

17 (Deposition Exhibit No. ##,
18 DESCRIPTION, was marked for
19 identification.)

20 - - -

21 BY MS. STEINMETZ:

22 Q. You've seen this pathology report
23 before. Right, doctor?

24 A. Yes.

25 Q. Specimen 1 includes vaginal mucosa

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(walmsley (mattingly).txt

REALTIME TRANSLATION - ROUGH EDIT ONLY 51

1 that consisted of several strips of mucosa up to 5
2 centimeters in length; is that correct?

3 A. Yes.

4 Q. And specimen 2, which was vaginal
5 mucosa from the rectocele included a strip of mucosa
6 3 centimeters in length?

7 A. Yes.

8 Q. Can removal of vaginal mucosa in the
9 anterior and posterior repairs change a woman's
10 vaginal caliber?

11 A. Yes.

12 Q. Can a change in vaginal caliber lead
13 to painful intercourse for a woman?

14 A. Yes.

15 Q. And can we agree that none of Ms.
16 Mattingly's treating physicians have identified mesh
17 exposed in the vagina?

18 A. I would agree.

19 Q. Can we agree that none of Ms.
20 Mattingly's treating physicians have identified a
21 mesh erosion into Ms. Mattingly's bladder or some
22 other internal organ?

23 A. I would agree.

24 Q. And can we agree that Ms. Mattingly
25 has never had any portion of the TVT or Prolene mesh

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REALTIME TRANSLATION - ROUGH EDIT ONLY 52

1 removed? (walmsley (mattingly).txt

2 A. I would agree.

3 Q. Is there any doctor in Ms.
4 Mattingly's medical records who mentioned
5 degradation of either of the mesh devices?

6 A. No did any of Ms. Mattingly's
7 treating physicians mention chronic inflammation or
8 a chronic foreign body response.

9 A. Well, yes, specifically Exhibit 8
10 speaks to the pathologic diagnosis of chronic
11 vaginitis.

12 Q. I'm sorry. What record are you
13 referring to?

14 A. The first page of Exhibit 8 at the
15 top. I think you asked me about chronic
16 inflammation?

17 Q. Okay. The -- the vaginal mucosa
18 taken from the area of the cystocele and the
19 rectocele notes some sort of chronic inflammation?

20 A. Chronic vaginitis as a pathologic
21 diagnosis.

22 Q. Anywhere else in Ms. Mattingly's
23 records where you saw that a doctor mentioned
24 chronic inflammation or foreign body response?

25 A. No.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 53

1 Q. Did any of Ms. Mattingly's treating
2 physicians mention loss of pore size of the TVT?

3 A. No.

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4 Q. Did any of Ms. Mattingly's treating
5 physicians mention that the TVT mesh had frayed or
6 roped or curled?

7 A. No.

8 Q. Did any of Ms. Mattingly's treating
9 physicians mention mesh contraction?

10 A. No.

11 Q. Did any of Ms. Mattingly's treating
12 physicians mention excessive scarring at or near the
13 TVT mesh?

14 A. No.

15 Q. Did any doctor mention the term
16 fibrotic bridging?

17 A. No.

18 MS. STEINMETZ: All right. This is a
19 good stopping point. Do you mind if we take a quick
20 five minute break, doctor?

21 THE WITNESS: Not at all.

22 MS. STEINMETZ: Great. We've been
23 going about an hour or so.

24 THE WITNESS: Okay.

25 (A recess was taken from 3:32 p.m. to

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REALTIME TRANSLATION - ROUGH EDIT ONLY 54

1 3:41 p.m.)

2 BY MS. STEINMETZ:

3 Q. Doctor, let's turn back to your
4 report as Exhibit 2. Your case-specific opinions
5 start on page 6 and there are three of them is that

(walmsley (mattingly).txt
6 right?

7 A. Yes.

8 Q. Case-specific opinion 1 specifically
9 relates to Ms. Mattingly's complaints about vaginal
10 pain and dyspareunia; correct?

11 A. Yes.

12 Q. I want to talk about each one
13 separately. First, the dyspareunia.

14 A. Okay.

15 Q. Looking at the top of page 7, and you
16 say Ms. Mattingly's dyspareunia has no clear
17 etiology; correct?

18 A. Yes.

19 Q. And you believe to a reasonable
20 degree of medical certainty that her dyspareunia
21 began after her pelvic surgeries?

22 A. That's correct.

23 Q. And you were speaking of her surgery
24 in 2009 as well as her surgery in 2011; correct?

25 A. You're asking me if she had had

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REALTIME TRANSLATION - ROUGH EDIT ONLY 55

1 dyspareunia before her pelvic floor surgeries in
2 2009, I believe; correct?

3 Q. Well, I think the answer we can both
4 agree is no to that.

5 A. Yeah, she did not experience painful
6 intercourse before March of 2009.

7 Q. So you note that the dyspareunia
8 began after her pelvic surgeries, and I'm wondering
Page 50

(walmsley (mattingly).txt

9 what you are referring to.

10 A. Well, she had multiple pelvic
11 surgeries by Dr. Angel I guess in one setting, if
12 you will.

13 Q. Okay.

14 So this use of the term pelvic
15 surgeries refers to the one surgery in 2009 which
16 included multiple components?

17 A. That's fair, yes.

18 Q. And you cannot determine, as you sit
19 here today, to what extent, if any, Ms. Mattingly's
20 dyspareunia was caused specifically by the TVT; is
21 that correct?

22 A. Yes.

23 Q. In other words, am I correct that you
24 are unable to state to a reasonable degree of
25 medical certainty that the TVT is the cause of her

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REALTIME TRANSLATION - ROUGH EDIT ONLY 56

1 dyspareunia?

2 A. I wouldn't put it that way. I would
3 list it as a causative factor, but I would have to
4 entertain in the differential the other surgeries
5 she had as well.

6 Q. As you sit here today, is it your
7 opinion that the TVT is the sole cause of her
8 dyspareunia?

9 A. No.

10 Q. And you believe an IME might shed

(walmsley (mattingly).txt
11 light on the cause of her dyspareunia?
12 A. I do.
13 Q. But you have not done an IME nor have
14 you been asked to do an IME as of today; correct?
15 A. That's correct.
16 Q. And you would agree that an IME may
17 also not shed light on the cause of her dyspareunia;
18 correct?
19 A. Possibly.
20 Q. In terms of a differential diagnosis
21 for her dyspareunia, are you able to rule out as the
22 cause of Ms. Mattingly's dyspareunia the concomitant
23 anterior repair Dr. Angel did in March of 2009?
24 A. You're asking me to rule that out?
25 Q. I'm asking are you able to rule it

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REALTIME TRANSLATION - ROUGH EDIT ONLY 57

1 out as the cause of her dyspareunia?
2 A. No.
3 Q. Are you able to rule out as the cause
4 of Ms. Mattingly's dyspareunia the concomitant
5 posterior repair that Dr. Angel did in March of
6 2009?
7 A. I'm not able to rule that out.
8 Q. Are you able to rule out as the cause
9 of Ms. Mattingly's dyspareunia a potential change to
10 her vaginal caliber that resulted from the 2009
11 surgery?
12 A. Could you repeat the question again?
13 I'm sorry.

(walmsley (mattingly).txt

14 Q. Sure. Are you able to rule out as
15 the cause of Ms. Mattingly's dyspareunia a potential
16 change to her vaginal caliber that may have resulted
17 from the 2009 surgery?

18 A. I would -- I would agree with that.

19 Q. Are you able to rule it out as the
20 cause of her dyspareunia?

21 A. I'm not.

22 Q. Are you able to rule out as the cause
23 of Ms. Mattingly's dyspareunia the prolapse surgery
24 Dr. Shively did in May of 2011?

25 A. I am not.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 58

1 Q. And you mention in your report that
2 you are able to rule out the cause of Ms.
3 Mattingly's dyspareunia -- strike that. You mention
4 in your report that you are able to rule out as the
5 cause of Ms. Mattingly's dyspareunia vaginal
6 scarring with reduced elasticity in the area of the
7 TVT implant.

8 A. Correct.

9 Q. Is that correct?

10 A. Correct.

11 Q. That is because -- and that is
12 because there's no evidence to support this
13 potential mesh-related cause?

14 A. I don't know if I understand that
15 question. I'm sorry.

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16 Q. Let me pull it right from your
17 report.

18 You state in your report the one
19 other plausible mesh-related cause for Ms.
20 Mattingly's pelvic pain and dyspareunia, vaginal
21 scarring with reduced elasticity, is also not seen
22 within the medical records; is that right?

23 A. Yes.

24 Q. So by virtue of the fact that there
25 is no evidence of that in the record, that's why

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REALTIME TRANSLATION - ROUGH EDIT ONLY 59

1 you're able to exclude it as a potential cause?

2 A. Based on that, yes.

3 Q. And the same thing with neuromuscular
4 injury; you're able to rule that out as the cause of
5 her dyspareunia given the absence of any evidence in
6 the records?

7 A. Correct.

8 Q. Staying with case-specific opinion
9 number 1, let's talk about Ms. Mattingly's vaginal
10 pain. Now, do you believe to a reasonable degree of
11 medical certainty that her vaginal pain began after
12 her pelvic surgery in 2009?

13 A. I would agree with that, yes.

14 Q. Are you aware of any evidence in the
15 records that she had vaginal pain preimplant?

16 A. Not to my knowledge.

17 Q. The pain that we saw related to that
18 bladder pain that we talked about earlier?

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19 A. Correct. I was looking at that, but
20 as I understand your question, I would say no. I
21 mean, that's talking about bladder pain and not
22 vaginal pain.

23 Q. Okay. Is your opinion on vaginal
24 pain similar to dyspareunia where you believe it has
25 no clear etiology?

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REALTIME TRANSLATION - ROUGH EDIT ONLY 60

1 A. I think -- really I think there are
2 many etiologies. It would probably be a better
3 representation to say, although there may not be any
4 clarity etiologies because there's several on the
5 differential. The fact that she had it is fairly
6 clear. The time course around which it took place
7 and developed is fairly defined to my knowledge.

8 Q. As you sit here today, is it your
9 opinion that the TVT is the sole cause of Ms.
10 Mattingly's vaginal pain?

11 A. That is not my opinion.

12 Q. In terms of a differential diagnosis,
13 are you able to rule out as the cause of Ms.
14 Mattingly's vaginal pain the concomitant anterior
15 repair Dr. Angel did in March of 2009?

16 A. I am not.

17 Q. Are you able to rule out as the cause
18 of Ms. Mattingly's vaginal pain the concomitant
19 posterior repair Dr. Angel did in March of 2009?

20 A. I am not.

(walmsley (mattingly).txt
21 Q. Are you able to rule out as the cause
22 of Ms. Mattingly's vaginal pain a potential change
23 to her vaginal caliber that resulted from the March
24 2009 surgery?
25 A. I am not.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 61

1 Q. Are you able to rule out as the cause
2 of Ms. Mattingly's vaginal pain the prolapse surgery
3 Dr. Shively did in May of 2011?
4 A. Could you repeat the question? I'm
5 sorry.
6 Q. Sure.
7 Are you able to rule out as the cause
8 of Ms. Mattingly's vaginal pain the prolapse surgery
9 Dr. Shively did in May 2011?
10 A. I'm not.
11 Q. Now, you mention at the bottom of
12 page 6, the third line up, pelvic pain and
13 dyspareunia. Are you using pelvic pain
14 interchangeably with vaginal pain?
15 A. To some extent. I mean, I do think
16 they're overlapping, if you will.
17 Q. Would your opinions and your
18 differential diagnosis, with those be the same
19 answers for pelvic pain as you just gave me for
20 vaginal pain?
21 A. To some extent, yes.
22 Q. And also with respect to pelvic pain,
23 are you able to rule out as a cause the mere

(walmsley (mattingly).txt

24 continuation of symptomology that Ms. Mattingly had
25 preimplant?

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REALTIME TRANSLATION - ROUGH EDIT ONLY 62

1 A. well, what symptoms are you speaking
2 of? I'm sorry.

3 Q. The pelvic pain symptoms that we
4 spoke of earlier.

5 A. Oh, you're talking about the bladder
6 pain from the questionnaire?

7 Q. Yes.

8 A. Yeah, I think that obviously was a
9 preceding factor more once again related to bladder
10 pain van vaginal pain.

11 Q. Okay.

12 A. But certainly in the realm -- in the
13 realm of pelvic pain, absolutely.

14 Q. So to the extent Ms. Mattingly
15 complains of pelvic pain currently, you are unable
16 to rule out the fact that this is a mere
17 continuation of symptomology that existed
18 preimplant; is that fair?

19 A. As it relates to that pain when her
20 bladder is full, I would agree, yeah.

21 Q. Now, case-specific opinion number 2
22 relates to Ms. Mattingly's urinary complaints of
23 stress urinary incontinence, urgency and incomplete
24 bladder emptying; correct?

25 A. Yes.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 63

- 1 Q. Can we agree that there is no
2 evidence in the record that Ms. Mattingly has urge
3 incontinence?
4 A. I wouldn't agree with that.
5 Q. You would or would not? Sorry.
6 A. I felt like at least she had some
7 symptoms consistent with mixed urinary incontinence.
8 Q. And I'm speaking of post TVT implant?
9 A. Oh, post TVT -- I'm sorry. I --
10 Q. Yes. So let me ask the question
11 again.
12 A. Yes, please.
13 Q. After the TVT was implanted in March
14 of 2009 --
15 A. Yes.
16 Q. -- can we agree that there has been
17 no evidence of urge incontinence?
18 A. Yes.
19 Q. With respect to the urinary urgency,
20 did you perform a differential diagnosis?
21 A. Yes.
22 Q. Are you able to rule out infection as
23 a cause of Ms. Mattingly's -- strike that. Are you
24 able to rule out infection as the cause of Ms.
25 Mattingly's urinary urgency?

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REALTIME TRANSLATION - ROUGH EDIT ONLY 64
Page 58

(walmsley (mattingly).txt

1 A. I'm not able to rule that out,
2 although she did have one visit where she had
3 urgency in the absence of a UTI, to be fair.

4 Q. Are you speaking of Dr. Kriegler's
5 records?

6 A. Yes.

7 Q. And we can agree that Ms. Mattingly
8 had urgency before the TVT was implanted; correct?

9 A. Yes.

10 Q. Can you point to any record that says
11 that her urinary urgency became worse or more
12 frequent after the TVT was implanted?

13 A. I cannot.

14 Q. Given that Ms. Mattingly's urinary
15 urgency pre-existed the TVT, are you able to rule
16 out the possibility that this is just a continuation
17 of a problem unrelated to the sling?

18 MR. BARRECA: Objection to form.

19 THE WITNESS: Well, it's hard for me
20 to do that only because since the sling is now in,
21 it has to be considered, you know, in the
22 development or ongoing change in her voiding
23 symptoms.

24 BY MS. STEINMETZ:

25 Q. Okay. Maybe I didn't ask the

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REALTIME TRANSLATION - ROUGH EDIT ONLY 65

1 question right.

(walmsley (mattingly).txt
2 So we know that Ms. Mattingly had
3 urgency or symptoms of urgency before the TVT went
4 in; correct?

5 A. Yes.

6 Q. And she's complaining of urgency to
7 her doctors at the present time; correct?

8 A. Yes.

9 Q. Can you rule out the possibility that
10 her symptomology is a continuation of a pre-existing
11 problem as opposed to something related to the mesh
12 sling?

13 MR. BARRECA: Objection to form.

14 THE WITNESS: I wouldn't rule that
15 out.

16 BY MS. STEINMETZ:

17 Q. Now your case specific opinion number
18 2 references stress urinary incontinence. Is your
19 reference to current stress urinary incontinence
20 related solely to the subjective complaints Ms.
21 Mattingly made to Dr. Kriegler at office visits on
22 October 15th, 2014 and October 31st, 2014?

23 A. Yes.

24 Q. And in those records, Dr. Kriegler
25 notes that she complained of mild SUI or stress

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REALTIME TRANSLATION - ROUGH EDIT ONLY 66

1 urinary incontinence?

2 A. Yes.

3 Q. Can you point to any record between
4 2009, when the TVT was implanted, and October 2014

(walmsley (mattingly).txt

5 evidencing symptoms of stress urinary incontinence?

6 A. I cannot.

7 Q. And can you point to any record
8 between October 2014 and the present evidencing
9 symptoms of stress urinary incontinence?

10 A. Yes.

11 Q. Where is that record?

12 A. In the October 15th, 2014 visit and
13 in the October 31st, 2014 visit.

14 Q. Okay. Sorry. You took me literally.
15 So can you point to any evidence or record between
16 November 1st of 2014 and the present that mentions
17 stress incontinence?

18 A. No.

19 Q. Did you read Ms. Mattingly's
20 testimony where she told me she does not really
21 experience leakage with coughs, laughs, and sneezes?

22 A. Yes.

23 Q. And are you aware based on your
24 review of Dr. Kriegler's records that Ms. Mattingly
25 did not report symptomology of stress incontinence

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REALTIME TRANSLATION - ROUGH EDIT ONLY 67

1 for the last several visits he had with her in 2015
2 and 2016?

3 A. Yes.

4 Q. And you will agree with me that Dr.
5 Kriegler did two cystoscopies, one in 2014 and one
6 in 2015, that were both normal?

(walmsley (mattingly).txt
7 A. Yes.

8 Q. would you defer to Dr. Kriegler, who
9 is Ms. Mattingly's treating urologist, for
10 information about Ms. Mattingly's urinary condition
11 and diagnosis?

12 A. Yes.

13 Q. Is it possible that Ms. Mattingly
14 perceived symptoms of stress incontinence at the two
15 visits in October of 2014 due to an ongoing urinary
16 tract infection?

17 A. No.

18 Q. And what is your basis for that
19 response?

20 A. well, there were two visits. During
21 her first visit, she did make mention of UTI
22 symptoms, which actually she has in several other
23 areas of the medical record, symptoms in the absence
24 of a real UTI. Be that as it may, she was treated
25 with Bactrim DS, an antibiotic at that time, yet

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REALTIME TRANSLATION - ROUGH EDIT ONLY 68

1 presented back two weeks later roughly with the same
2 exact symptoms despite treatment for the UTI.

3 Q. what is your explanation for mild
4 stress incontinence symptoms as perceived by the
5 patient which occur, you know, within a 30-month
6 period but then go away?

7 A. I think you mean a 30-day period.
8 Right?

9 Q. Oh, sorry. Yes.
Page 62

(walmsley (mattingly).txt

10 A. That's okay. Well, I mean, I think
11 there are two implications from that. I mean we've
12 all seen medical records where sometimes symptoms
13 aren't documented because they aren't asked and
14 answered so I mean one explanation may be that she's
15 continuing to have these symptoms, but doesn't bring
16 it up with the clinician because perhaps she isn't
17 -- either is not bothered by it that much or she
18 doesn't see any sort of solution or change.

19 Q. If Dr. Kriegler testified that Ms.
20 Mattingly's perceived stress incontinence may have
21 related to her infections in the past, would you
22 disagree with that possibility?

23 A. I wouldn't necessarily disagree with
24 it, but I'd like to understand his analysis of per
25 symptoms on October 31st, 2014 in that vein --

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REALTIME TRANSLATION - ROUGH EDIT ONLY 69

1 Q. And by that, you're talking about the
2 use of the antibiotics not resolving the stress
3 incontinence symptoms?

4 A. Correct.

5 Q. And in that response, are you making
6 an assumption that Ms. Mattingly would be responsive
7 to whatever antibiotic was prescribed to her?

8 A. Well, I wouldn't see why not. I
9 mean, Bactrim DS is a very good choice of drug to
10 empirically treat an infection. Unfortunately, I
11 don't recall seeing a urine culture that otherwise

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12 would have clued us in as to even if she had an
13 infection, number one, but, number two, if it was a
14 particular kind of bacteria. But for most UTIs, the
15 choice of a sulfa antibiotic is a very good one.

16 Q. Coming back to the original question,
17 I want to ask it a different way: How do you
18 explain perceived symptoms of mild stress
19 incontinence two times with no complaints before and
20 no complaints after and two times in a 14-day
21 window?

22 A. Well, I mean, I think one thing we
23 have to understand is, taking aside or putting aside
24 getting a complete history and physical from a
25 patient, maybe she might not have mentioned it to

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REALTIME TRANSLATION - ROUGH EDIT ONLY 70

1 that point we were discussing before, but the other
2 thing that can also happen is, as chronic
3 inflammation, scarring occurs within the vaginal
4 space, this is a dynamic process, and I think one
5 example of kind of just demonstrating that is the
6 fact that Mrs. Mattingly's pain has evolved to a
7 worsening degree continuously since her surgeries.
8 So the fact that things might change, that maybe her
9 sling might contract, for example, and go from being
10 too loose to being too tight and her then developing
11 incomplete emptying, that might be a plausible way
12 to explain why her symptoms did change, because
13 that's kind of what happened to her. She went from
14 having mild SUI to actually having voiding

(walmsley (mattingly).txt

15 dysfunction requiring Flomax, so it's as if, from my
16 analysis, the sling tightened over time and went
17 from being too loose, mild SUI, to being so tight
18 that now she's not urinating properly.

19 Q. Do you see any evidence in the
20 records that Dr. Angel improperly placed the sling?

21 A. I do not. In fact, I would say to
22 the contrary, I see evidence to the fact that he did
23 so using proper technique.

24 Q. And do you see any evidence in the
25 record of excessive or abnormal scarring in or

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REALTIME TRANSLATION - ROUGH EDIT ONLY 71

1 around the area of the sling?

2 A. Well, no, because that -- we haven't
3 had a possibility to examine tissue in that area.

4 Q. Did you note in the record any
5 evidence of mesh contraction?

6 A. Well, indirectly, yes.

7 Q. What evidence is that?

8 A. Well, I think the evidence is more
9 applicable to how they are symptoms evolved to the
10 point of your question before.

11 Q. And you're speaking of the symptoms
12 that she eventually ended up with difficulty
13 emptying her bladder?

14 A. Well, I think there were two things
15 that have occurred. One of them is that difficulty
16 in emptying the bladder, in other words, the sling

(walmsley (mattingly).txt
17 becoming too tight over time, contracting over time,
18 if you will.

19 Q. And what's the second thing?

20 A. Well, the other's the pain, the fact
21 that her pain has been worsening since the implant.

22 Q. Believe it or not, we were on the
23 topic of stress incontinence and I wanted to ask you
24 about some testimony from Dr. Kriegler which I know
25 you did not read --

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REALTIME TRANSLATION - ROUGH EDIT ONLY 72

1 A. Yes.

2 Q. If Kim could hand you a copy of his
3 transcript, that would be great.

4 (Pause.)

5 BY MS. STEINMETZ:

6 Q. If you can turn to page 39, Doctor,
7 of Dr. Kriegler's transcript -- are you there?

8 A. I am.

9 Q. -- line 13, question: Can a urinary
10 tract infection affect a woman's incontinence answer
11 yes. Question. I mean is stress incontinence a
12 symptom of a urinary tract infection. Answer it's
13 more of an urge incontinence more than stress but an
14 infection causes severe irritation to the nerves of
15 the bladder base, which causes severe frequency and
16 urgency and when the bladder is that irritated, if
17 you cough, just the abdominal impulse hitting the
18 bladder can trigger a contraction."

19 First, did I read that accurately?

(walmsley (mattingly).txt

20 A. You did.

21 Q. Okay. Do you agree with that
22 statement by Dr. Kriegler?

23 A. Which statement? Because you read a
24 bit of his testimony.

25 Q. The last statement about the fact

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REALTIME TRANSLATION - ROUGH EDIT ONLY 73

1 that a urinary tract infection can, in an indirect
2 way, cause that abdominal impulse that triggers the
3 incontinence.

4 A. Yes, I do agree with that statement.

5 Q. Are you able to rule out infection as
6 the cause of Ms. Mattingly's perceived stress
7 incontinence at these two visits in October of 2014?

8 A. I am.

9 Q. And tell me how you're able to rule
10 it out.

11 A. Well, perhaps I can refer you to page
12 40 of the deposition, where -- and going from the
13 bottom of page 39 to 40, he's asked, okay, so in Ms.
14 Mattingly's case, it's entirely possible that her
15 symptomology of stress incontinence at least of the
16 first of the time of this first visit may have been
17 related to an active urinary tract infection to
18 which he answers, no, because her urine analysis
19 didn't show an active infection.

20 Q. Right. Okay. Hold on. Let me point
21 you to one more place. On page 49, line 14, the

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22 question was were you able to objectively confirm
23 her stress incontinence. The answer was no.
24 Question: Does that lead you to believe that the
25 stress incontinence that she received was related to

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REALTIME TRANSLATION - ROUGH EDIT ONLY 74

1 perhaps ongoing infections in the past? Answer:
2 Good possibility.
3 So I think to some extent, would you
4 agree that Dr. Kriegler was agreeing that the stress
5 incontinence symptomology may have been related to
6 past infections?
7 A. I actually interpret it -- I make a
8 completely different conclusion to that particular
9 body of questioning. My conclusion there is that
10 he's admitting that SUI symptoms can be worsened
11 with a superimposed infection. That's the
12 conclusion I make from his statement, that I'm not
13 going to tell you that a urinary tract infection
14 won't make incontinence worse although usually it is
15 urgency incontinence. What I'm saying that,
16 particularly as it relates to October of 2014, in
17 the absence of an infection, I would rule it out.
18 But generally speaking, sure, a UTI could make SUI
19 worse, I would agree with that. And I think that's
20 what he's saying. Stress incontinence can be
21 worsened by ongoing infections, but the fact that
22 she doesn't have an infection in October of 2014 and
23 he's also said her urine culture was negative, I
24 think if you were to ask the question specifically

(walmsley (mattingly).txt

25 the way I'm thinking about it, he would agree with

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REALTIME TRANSLATION - ROUGH EDIT ONLY 75

1 my analysis perhaps more than yours, I respectfully
2 submit, although I may be wrong.

3 Q. Okay.

4 The sling was initially intended to
5 alleviate Ms. Mattingly's stress incontinence.

6 Right?

7 A. Yes.

8 Q. That's the indication for the sling?

9 A. I agree.

10 Q. And are mesh slings known to have a
11 potential complication of stress incontinence?

12 A. I mean, I wouldn't necessarily put it
13 that way but I think the recurrence of stress
14 incontinence can occur after a sling and I think
15 patients need to be counseled towards that
16 possibility.

17 Q. Okay. And then just to wrap this up,
18 other than those two visits in October 2014 when Ms.
19 Mattingly told Dr. Kriegler about mild stress
20 incontinence symptoms, are you aware of any other
21 evidence in the record that the sling was not
22 working to resolve that problem for her?

23 A. I do not.

24 Q. Let's talk about the incomplete
25 bladder emptying that you mention in case specific

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REALTIME TRANSLATION - ROUGH EDIT ONLY 76

1 opinion number 2.

2 Now, does this refer to complaints
3 that Ms. Mattingly made to Dr. Kriegler during her
4 care and treatment of him?

5 A. Yes.

6 Q. Sorry. With him? All right.

7 Now, can you point to any evidence of
8 a heightened postvoid residual showing that Ms.
9 Mattingly is objectively unable to empty her
10 bladder?

11 A. The incomplete bladder emptying from
12 an objective standpoint is only about 44 cc's. That
13 was based on her last visit, at least the one
14 documented in my report from April of 2016.

15 Q. And do you consider 44 cc's to be
16 above the threshold where you would characterize a
17 patient as in retention?

18 A. I think it would be determined as
19 mild at best, although in a lot of instances, in
20 terms of diagnosing bladder outlet obstruction, of
21 which incomplete bladder emptying can be a symptom
22 because I believe she does have bladder outlet
23 obstruction, really the best way to determine that's
24 with a urodynamics study because in the setting of
25 an overactive bladder, you know, overactive bladders

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REALTIME TRANSLATION - ROUGH EDIT ONLY 77

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1 typically exert so much pressure that you would get
2 better emptying. In other words it's entirely
3 plausible that Mrs. Mattingly has an elevated, you
4 know, postvoid residual that's not as bad as it
5 should be because she has an overactive bladder that
6 more or less compensates for the incomplete emptying
7 if that makes sense.

8 Q. It does. And the overactive bladder
9 was a symptom that was present even before the sling
10 went in; correct?

11 A. Yes and no. I mean as we discussed
12 before, she had symptoms of urgency but she really
13 didn't meet frequency criteria to fall into, at
14 least in a clean fashion, into an overactive bladder
15 symptom category. Her urgency may have been -- you
16 know, sometimes urgency can be related to behavioral
17 or lifestyle factors as well, to be fair.

18 Q. Does she meet the frequency criteria,
19 at least during her care and treatment with Dr.
20 Kriegler?

21 A. You know, I'd have to look back at
22 his records more specifically to answer that
23 question.

24 Q. Let me ask you this: Can you point
25 to any record that indicates that her overactive

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REALTIME TRANSLATION - ROUGH EDIT ONLY 78

1 bladder symptomology is worse or more frequent after
2 the TVT than before?

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3 A. well, I think what's interesting to
4 me about anterior overactive bladder symptoms is
5 that they seem to be more prevalent afterwards only
6 because there's a bit of an overlap between her
7 pain, recurrent UTI, voiding dysfunction symptoms
8 that all kind of have overactive bladder symptoms
9 within them. I'm not denying that for example she
10 had urgency before the surgery. She's filled out a
11 questionnaire that speaks to that, but the fact that
12 there have been multiple office visits relating to
13 those symptoms more so now than in her prior history
14 would lead me to conclude with reasonable certainty
15 that her overactive bladder symptoms are worse, at
16 least quantitatively or quantitatively worse, if you
17 will.

18 Q. Have you done any kind of an analysis
19 of that statistically speaking?

20 A. I mean, my statistical analysis is
21 really only on the basis of the medical records. In
22 other words, you know, if I was to look at her
23 medical records for seven years before 2009, so I'm
24 looking at seven years before 2009 and seven years
25 after, maybe controlling those variables, I would

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REALTIME TRANSLATION - ROUGH EDIT ONLY 79

1 submit to you that overactive bladder symptoms, as
2 it were, were much more prevalent in the
3 post-implant realm than pre. That's my point.

4 Q. Now, with respect to the inability to
5 empty the bladder, that was a symptom that she also

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6 reported preimplant; correct?

7 A. I believe so, yes. Yes.

8 Q. Are you able to rule out the
9 possibility that her inability to empty the bladder
10 is simply a continuation of a pre-existing problem
11 unrelated to the mesh?

12 A. Once again, I feel like her
13 complaints of that, whether subjective or objective,
14 were more -- you know, more vigorous and more
15 relevant in the post-implant setting, so I wouldn't
16 rule it out entirely, but I would give it less
17 consideration, if you will.

18 Q. When you talk about objective
19 criteria, I asked you this before and I just want to
20 make sure what the answer is, what is the threshold
21 of the postvoid residual number?

22 A. Well, you know, incomplete bladder
23 emptying can be determined from two standpoints.
24 One's the absolute volume, so, for example, usually
25 over 150 cc's in a man or a woman for that matter

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1 raises a bit of concern to me. But anything over 25
2 to 50 milliliters, I would consider some form of
3 mild incomplete emptying. But the other relevance
4 finding which is a urodynamic finding is that of
5 voiding efficiency. So what I mean when I say that
6 is, for someone who has a 250 cc capacity bladder to
7 have a postvoid residual of 50 cc's to me is much

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8 more relevant than someone who has a 500 milliliter
9 capacity, having a postvoid residual of 50 cc's,
10 because that would in essence translate from a
11 voiding efficiency of 90 percent to, you know, a
12 voiding efficiency of like 70, 75 percent for the
13 smaller bladder. And I think that Mrs. Mattingly
14 kind of falls into the category of someone who has
15 a, by all accounts maybe a modest postvoid residual
16 but it's more meaningful to her because of the fact
17 that her bladder capacity has been somewhat
18 compromised on the basis of her pelvic surgeries.

19 Q. Are you able to rule out infection as
20 the cause of Ms. Mattingly's incomplete bladder
21 emptying?

22 A. I am.

23 Q. On what basis?

24 A. On the basis of her having those
25 symptoms in the absence of infections.

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REALTIME TRANSLATION - ROUGH EDIT ONLY 81

1 Q. Now, I know you did not review Dr.
2 Kriegler's testimony, but he attributed her
3 incomplete bladder emptying symptomology in the
4 absence of an infection to spasms for which he
5 prescribed medication. Are you aware of that based
6 on the records?

7 A. Yeah, I'm trying to recall which
8 medications he prescribed.

9 Q. I think he initially tried tamsulosin

10 --

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11 A. Right, right.

12 Q. And then terazosin?

13 A. Yep.

14 Q. My question to you is, are you able
15 to rule out spasms as the cause of Ms. Mattingly's
16 perceived incomplete bladder emptying?

17 A. Yes.

18 Q. On what basis are you able to rule
19 that out?

20 A. On the basis of the interventions
21 used by Dr. Kriegler to treat her voiding
22 dysfunction.

23 Q. And what do you mean by that?

24 A. So tamsulosin and terazosin are both
25 in a class of drug called alpha blockers. Alpha

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1 blockers are medications that actually are typically
2 used more often in men with voiding dysfunction as
3 opposed to women. For example, tamsulosin which is
4 known as Flomax is used to treat a condition called
5 BPH or benign prostatic hypertrophy. It relaxes the
6 smooth muscle tone, if you will, of the lower
7 urinary tract and prostate. It has been shown to
8 have some benefit in women who have bladder neck
9 obstruction. Typically, these medications are used
10 to relieve the pelvic floor muscular tone of the
11 bladder neck. They are not indicated to treat
12 bladder spasm.

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13 Q. If Dr. Kriegler testified that he
14 believes that her incomplete bladder emptying is due
15 to incomplete bladder -- strike that. If he
16 testified that he believes her incomplete bladder
17 emptying is due to spasms, I take it you would
18 disagree with him?

19 A. Respectfully, I would, yes.

20 Q. All right. We spoke about the
21 urinary urgency, the stress incontinence, and the
22 incomplete emptying. Are there any other urinary
23 problems that you believe may relate to the TVT?

24 A. Did we discuss recurrent SUI or no?

25 Q. Yes.

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1 A. Okay.

2 Q. We talked about your case-specific
3 opinion 2, which included complaints of stress
4 incontinence, urgency, and incomplete bladder
5 emptying.

6 A. Correct.

7 Q. Are there any other urinary
8 complaints that you attribute to the TVT?

9 A. No.

10 Q. Do you attribute -- strike that. Do
11 you believe that Ms. Mattingly's urinary tract
12 infection symptomology is in any way related to the
13 TVT?

14 A. You said urinary tract infection
15 symptomology?

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16 Q. Yes.

17 A. The answer to that is yes.

18 Q. And we can agree that Ms. Mattingly
19 had a history of bladder infections before the mesh
20 went in?

21 A. This is true.

22 Q. Can you point to any record that says
23 that her urinary tract infections are worse or more
24 frequent now than before the TVT?

25 A. Well I think the medical records

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REALTIME TRANSLATION - ROUGH EDIT ONLY 84

1 speak for themselves relating to that question.

2 Q. Well, I guess my question is a little
3 bit more specific: Can you point to a record that
4 suggests that these UTIs have gotten worse?

5 A. I mean, once again, I would say from
6 a qualitative standpoint, maybe not, but from a
7 quantitative standpoint, I would say that's kind of
8 asked and answered just by virtue of the fact that
9 over the proceeding years after her sling implant,
10 there were many more healthcare related visits
11 because of her UTIs. The only problem, to be fair,
12 is that some of her UTIs were not even in fact UTIs.
13 They were just other pelvic pain-related requests,
14 so I guess to be fair to your question, I wouldn't
15 say there's overwhelming evidence to suggest it, but
16 certainly there are -- there is more attention paid
17 to it, shall we say, after her surgery in 2009.

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18 Q. And to be fair, other than the
19 records from Dr. Angel, are you aware of any urology
20 records or primary care records in this case that
21 were collected that show how frequent Ms. Mattingly
22 was having UTIs before the mesh was implanted?
23 A. I mean, the only real way to answer
24 the question, which is not optimal, is to -- is
25 really her deposition itself, which really doesn't

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1 illustrate the fact that she had a lot of problems
2 with recurrent UTIs prior to her procedure.
3 Q. Are you aware that Dr. Kriegler's
4 testing number objectively confirmed a UTI at any of
5 these visits?
6 A. I am, yes.
7 Q. And do you defer to the findings of
8 Dr. Kriegler as far as her diagnosis of urinary
9 tract infections?
10 A. I do.
11 Q. Do you associate a properly placed
12 mid-urethral mesh sling with urinary tract
13 infections?
14 A. Possibly.
15 Q. And that's for the reasons you stated
16 earlier, where it may scar over time and cause the
17 patient some sort of obstructive symptoms?
18 A. That's correct.
19 Q. Are there any other causes of Ms.
20 Mattingly's recurrent UTIs that you considered in

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21 your differential diagnosis?

22 A. Other than what exactly?

23 Q. Other than the sling and her
24 pre-existing history.

25 A. Well I think her pre-existing

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1 history, which would include some voiding
2 dysfunction before as well as incomplete emptying,
3 would have to be considered as well.

4 Q. Dr. Kriegler testified that he does
5 not causally relate any of Ms. Mattingly's urinary
6 complaints that he treated her for to the TVT sling.
7 I take it you disagree with Dr. Kriegler?

8 A. Would you reference the page that
9 you're speaking about on that?

10 Q. Sure, page 77 --

11 A. 37 you said?

12 Q. 77.

13 A. Okay.

14 Q. And I promise, I'm almost done,
15 doctor. Thank you for bearing with me.

16 A. No problem.

17 Q. And it's line 12, question: Do you
18 believe that any of Ms. Mattingly's symptoms or
19 problems that you treated her for were caused by the
20 mesh bladder sling? Answer: No. I guess my
21 question is, do you defer to Dr. Kriegler on that
22 point?

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23 A. Yes, I would agree with that, but I
24 mean I think --
25 Q. You would agree that you disagree?

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1 A. Well I agree but I would submit to
2 you that he really didn't treat any of the
3 underlying problems related to her mesh sling. I
4 mean for example he gave her Bactrim for a UTI that
5 wasn't even a UTI number one and then he treated the
6 patient with Flomax and terazosin for bladder outlet
7 obstruction at the end of the day really weren't
8 effective because those medications really don't
9 relax scar tissue. They relax smooth muscle so he
10 really didn't treat her for any of the complications
11 that we've discussed relating to the sling for the
12 most part. He gave her no medication for pain. I
13 don't see any treatment for pain, whether it be
14 physical therapy, discussions of sling revision or
15 removal, so, yeah, I mean, I think -- I think he's
16 being truthful.

17 He -- the symptoms -- the symptoms
18 and problems that he treated her for had nothing to
19 do with the complications of her mesh bladder sling.

20 Q. The last question on this topic, you
21 just mentioned scar tissue relaxation. Was there
22 any evidence in his records that he identified scar
23 tissue?

24 A. I don't recall such.

25 Q. Let's quickly run through case

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REALTIME TRANSLATION - ROUGH EDIT ONLY 88

- 1 specific opinion number 3 and then we will be
2 finished, doctor.
- 3 A. Okay.
- 4 Q. This opinion relates to prognosis.
5 True?
- 6 A. Yes.
- 7 Q. And you mentioned pelvic pain,
8 voiding dysfunction and dyspareunia; correct?
- 9 A. Yes.
- 10 Q. And this pelvic pain is essentially
11 interchangeable with the vaginal pain and also
12 pelvic pain that we were talking about in case
13 specific opinion number 1?
- 14 A. Yes, it would be all-encompassing.
- 15 Q. All right. With respect to her
16 voiding dysfunction, are you speaking of any urinary
17 problems or complaints other than those that we have
18 already discussed in connection with case specific
19 opinion number 2?
- 20 A. I am not.
- 21 Q. Am I correct that no physician has
22 recommended removal of Ms. Mattingly's TVT sling?
- 23 A. You are correct.
- 24 Q. Am I correct that you are not here
25 today recommending that she have the sling removed?

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REALTIME TRANSLATION - ROUGH EDIT ONLY 89

1 A. Not necessarily, not necessarily.

2 Q. Are there instances in your practice
3 where you have recommended immediate removal of a
4 mesh sling in order to alleviate a patient's
5 complaint?

6 A. Immediate removal?

7 Q. Well, you know, imminent removal,
8 whenever it can be done.

9 A. There are instances in which I have
10 removed mesh slings for the complaints of
11 pelvic/vaginal pain.

12 Q. And you talk about an autologous
13 fascial sling in the second to last paragraph on
14 page 8.

15 A. Yes.

16 Q. Now, am I correct that you are not
17 recommending an autologous sling for treatment of
18 any of Ms. Mattingly's current urinary issues?

19 A. Not at this time, no.

20 Q. And you talk in your report about how
21 autologous slings placed in the area of scar tissue
22 have a lower efficacy rate; correct?

23 A. Correct.

24 Q. And again just to be clear did you
25 see any evidence of scar tissue in or around the

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1 area that you are referring to here?

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2 A. Well, I've not examined the patient
3 so I can't really answer that question.

4 Q. Well, any evidence based on the
5 records you've reviewed. Or the depositions that
6 you have read.

7 (Pause.)

8 THE WITNESS: I do not.

9 BY MS. STEINMETZ:

10 Q. Okay. According to your report, your
11 treatment recommendations for Ms. Mattingly at this
12 time include medical therapy, lifestyle
13 modifications, and pelvic floor physiotherapy?

14 A. Correct.

15 Q. By medical therapy, what are you
16 referring to?

17 A. Well, a medication that might, for
18 example, address her overactive bladder symptoms,
19 things of that nature.

20 Q. And by lifestyle modifications, are
21 you referring to fluid intake and things of that
22 nature?

23 A. What kinds of fluid, how much fluid,
24 when to drink the fluid, yes.

25 Q. And are those related to her

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REALTIME TRANSLATION - ROUGH EDIT ONLY 91

1 overactive bladder symptoms as well?

2 A. I should also mention weight loss,
3 but yes.

(walmsley (mattingly).txt
4 Q. Pelvic floor physiotherapy, what are
5 you referring to here?

6 A. That's a form of physical therapy
7 that's directed by pelvic floor specialized trainees
8 that relates to my own fascial release-type
9 techniques.

10 Q. And what symptom or problem would you
11 recommend -- strike that. For what specific symptom
12 or problem would you recommend pelvic floor
13 physiotherapy?

14 A. Dyspareunia, vaginal foreshortening,
15 contraction-related injuries.

16 Q. I also wanted to ask you about Ms.
17 Mattingly's testimony that her low back pain
18 intensified after her surgery with Dr. Shively in
19 2011. Do you recall that testimony?

20 A. I do, yes.

21 Q. Are you offering any opinions in this
22 case about the cause of her low back pain?

23 A. Well I do think it could be related
24 to a surgery.

25 Q. In what way?

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1 A. Well, the type of procedure that he
2 performed utilizes the sacrospinous ligament and
3 that ligamentous area can be associated with back
4 pain or buttock pain because the sutures sometimes
5 can become entrapped and/or cause tension.

6 Q. And you are aware that Ms. Mattingly
Page 84

(walmsley (mattingly).txt

7 had back surgery in 2012?

8 A. I am.

9 Q. Do you associate Ms. Mattingly's back
10 issues or pain with any of the complaints that we've
11 talked about today?

12 A. I don't.

13 Q. In other words, do you think her back
14 pain could be referred to the pelvis?

15 A. Well, I do on that level, because for
16 -- for the same reasoning I provided relating to the
17 anatomical ligaments, if you will, used in the
18 sacrocolpopexy procedure that Dr. Shively performed.

19 Q. And you're aware that she had these
20 back issues even before the 2009 surgery with Dr.
21 Angel.

22 A. True, but, I mean, she does make
23 mention to her pelvic pain worsening and I think to
24 be fair, it wouldn't be fair, so to speak, to
25 exclude sacrospinous ligament either contraction or

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1 pain from the surgery as being in the differential
2 after Dr. Shively's surgery.

3 Q. Well, are you aware that she was
4 taking pain medication for some years even before
5 Dr. Angel put in the mesh and that's for her low
6 back pain?

7 A. I was aware of that, yes.

8 Q. Okay. So I guess my question is, are

9 (walmsley (mattingly).txt
you able to rule out unrelated back pain issues as
10 the cause of her pelvic pain post-implant?

11 A. Well, I mean assuming it's unrelated
12 to her pelvic pain, yes. I mean, if it's the back
13 pain that's typical of the back pain she had prior
14 to 2009, then I would agree with you.

15 Q. And you say at the end of your report
16 that you reserve the right to supplement and amend
17 this opinion should additional factual information
18 be forwarded to you that you did not have available.
19 Are you waiting on anything in particular?

20 A. The depositions primarily.

21 Q. And with respect to Ms. Mattingly's
22 prognosis, do you defer to treating physicians who
23 have seen her, you know, over the past couple years,
24 like Dr. Kriegler?

25 A. I would appreciate that information

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REALTIME TRANSLATION - ROUGH EDIT ONLY 94

1 and absolutely allow it to formulate my opinions.

2 Q. What was that answer? I'm sorry?

3 A. I guess the answer in fewer words is
4 yes.

5 MS. STEINMETZ: All right. Doctor, I
6 will let you off the hook. Those are all the
7 questions I have for you. Thank you for your time.

8 THE WITNESS: Thank you.

9 MS. STEINMETZ: Do you have anything
10 Rick?

11 MR. BARRECA: Yeah just real quick.

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12 Thanks for your testimony today by the way.

13 - - -

14 EXAMINATION

15 - - -

16 BY MR. BARRECA:

17 Q. Earlier today you've testified that
18 you've used Ethicon products before in your
19 practice; correct?

20 A. I have.

21 Q. And what do you customarily use
22 today?

23 A. I'm currently using a Coloplast
24 product. It's called the ARIS sling.

25 Q. And do you find it to be more

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REALTIME TRANSLATION - ROUGH EDIT ONLY 95

1 beneficial to your patients?

2 A. I prefer it in my patients, yes.

3 Q. Why is that?

4 A. Well, it's the same --

5 MS. STEINMETZ: Objection.

6 THE WITNESS: -- of mid-urethral
7 sling in the sense that it's lightweight,
8 polypropylene, and so forth. However, the ARIS
9 sling, when examined, you can tell it's less -- it
10 has less elasticity, so as a result, it doesn't have
11 the same contraction rate variability that some of
12 the more elastic-type slings have, so I tend to
13 prefer using it, because I can very reproducibly set

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14 the tension-free setting, if you will, with that
15 type of sling than I can with some of the other
16 slings, for example, the TVT-O sling which I've
17 palpated, has more elasticity. The TVT slings in
18 and of themselves are a little bit more elastic so
19 they tend to contract to a greater degree than the
20 Coloplast sling would.

21 Q. Is it fair to say that -- are there
22 ever times where one product manufacturer is more
23 beneficial than another?

24 A. I think --

25 MS. STEINMETZ: Object to the form.

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1 THE WITNESS: I mean, I think that
2 what happens with these devices is, you -- everyone
3 has kind of a nuance within the actual surgical
4 execution or thought process that you can adapt to,
5 so, you know, for that purpose, if I was on a Third
6 World island and someone handed me a Boston
7 Scientific sling, for example, I could still implant
8 it but I'd have to take into consideration, for
9 example, the fact that it might have a higher
10 contraction rate so I might want to set it a little
11 more loose or, you know, sleeve -- mesh sleeve
12 deployment, some of the products it's a little
13 harder to deploy the mesh sleeve. So, you know,
14 every -- I think every sling has kind of its
15 relative strength and weakness, so I have a
16 preference right now for the Coloplast device

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17 because I like the contraction-based advantage. But
18 I don't know if I could necessarily say within a
19 reasonable degree of medical certainty that one is,
20 let's say, better than the other, but I've been very
21 happy with Coloplast lately.

22 MR. BARRECA: Okay. Thank you very
23 much.

24

25

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REALTIME TRANSLATION - ROUGH EDIT ONLY 97

1

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2

EXAMINATION

3

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4

BY MS. STEINMETZ:

5

Q. Doctor, what is a Coloplast device

6

made of?

7

A. It's a polypropylene mesh sling.

8

Q. And you've been using polypropylene

9

mesh for how long?

10

A. In the pelvic space, since 2001.

11

Q. And are contraction rates or the fact

12

that mesh contracts anything new to you?

13

A. Not per se, no.

14

Q. I mean, when did you first learn

15

about mesh contraction? Was that when you first

16

started using these products in 2001?

17

A. Yes, I mean, more or less. I think

18

it was a more evolving -- you know, my relationship

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19 with mesh contraction changed quite a bit when I
20 started becoming the attending of record because a
21 lot of times as a resident or a fellow in training,
22 you're not necessarily seeing these patients in
23 follow-up, so inasmuch as you might understand the
24 phenomenon mechanistically speaking or
25 technique-speaking, you don't really have a full

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1 flavor for it until you really examine these
2 patients over time and then come to appreciate what
3 that phenomenon really means in a clinical setting.

4 Q. And you mentioned the
5 contraction-based advantage. What does that mean?

6 A. Well, it means exactly what I was
7 trying to state before, which is with certain slings
8 -- for example, the Bard Align sling, that has a
9 fairly high contraction rate and as a result of
10 that, when placing those slings, it's very, very
11 important to eron the side of looseness, if you
12 will, because of that contraction phenomenon,
13 because I have had instances, not many, but maybe 5
14 percent of my patients have had some degree of
15 bladder outlet obstruction and of those 5 percent,
16 I've probably had to release one-third of those
17 patients and that's about 1 in 50 for the Bard
18 Align. That's a meaningful enough number for me
19 that having a system in place that has a more
20 predictable contraction pattern is at -- you know,
21 pleasing to me, is something I want in a product.

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22 Q. Well, it sounds to me like you would
23 agree that surgeon technique plays into how these
24 meshes will work over the long term as far as
25 contraction goes.

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1 A. Well I think yes and no because then
2 we're just taking out of the equation host responses
3 and obviously different patients have different host
4 responses to mesh. I mean I've seen mesh slings
5 that have been implanted improperly and -- you know,
6 with severe complications. Then again I've also
7 seen mesh slings that have been placed properly that
8 have devastating complications, so sometimes the
9 host response is -- you know, it's a relevant
10 consideration in the analysis.

11 Q. So host response and surgeon
12 technique are both factors in that analysis.

13 A. I believe so, yes.

14 Q. And you would put the onus on the
15 surgeon to determine, you know, what product they're
16 using and whether or not they should place it loose
17 or not depending on how that product in particular
18 contracts over time.

19 A. Well, I don't think that's fair to
20 put the onus on the surgeon I mean I think that's
21 asking a lot. The only point I was trying to make
22 is that over time, as you do more and more work and
23 work with different products, you know, you develop

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24 nuances to trying to optimize patient outcomes. I
25 think people have preferences --

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REALTIME TRANSLATION - ROUGH EDIT ONLY 100

1 MS. STEINMETZ: Okay.
2 THE WITNESS: Right?
3 MS. STEINMETZ: Yes. Thank you for
4 your time, doctor.
5 THE WITNESS: Thank you.
6 (Witness excused.)
7 (Deposition ^ concluded ^ adjourned
8 at approximately ^ Time ^ a.m. ^ p.m.)
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